Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All BabyCare Providers participating in the Virginia Medical Assistance Programs, including Health Department Clinics, Federally Qualified Health Centers, Rural Health Clinics, Private Home Health Agencies, and Managed Care Organizations (MCOs)

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services (DMAS)

MEMO Special

DATE 9/16/2005

SUBJECT: Clarification of BabyCare Claims Process & FAMIS MOMS Eligibility for BabyCare Services

The purpose of this memorandum is to clarify the BabyCare claims process, highlight changes to the BabyCare claims submission process, provide newly revised BabyCare forms to use, and notify providers of the FAMIS MOMS program for BabyCare Services.

PROGRAM SERVICES

Pregnant women who have low income are at high risk of poor birth outcomes and need a variety of services to ensure they have healthy babies and the tools to become good mothers. BabyCare provides pregnant women with the support and services they need through intensive Case Management and Care Coordination. The program aims to improve birth outcomes by ensuring pregnant women and infants up to age two receive all the services they need. BabyCare may be provided through the local health district offices and a small number of private community organizations.

CLAIMS SUBMISSION

BabyCare claims are to be submitted to the Virginia Medicaid Management Information System (VAMMIS) through First Health Services Corporation (FHSC). Up until now, many providers were instructed to send claims directly to Nell Skinner's attention for processing if the claims were older than one year or if providers were experiencing problems with VAMMIS. This is no longer necessary.

Effective November 1, 2005, follow the billing guidelines below:

Start mailing ALL CMS-1500 (12-90) Claim Forms directly to the following address for processing:

DMAS/First Health
P.O. Box 27444
Richmond, VA 23261-7444

- Any claim mailed to Nell Skinner/BabyCare after November 1, 2005, will be returned to the provider to resubmit to DMAS/First Health.

- **ALL claims for risk screens and expanded prenatal services must have a copy of the risk screen attached to the claim and include the following coding in the proper boxes for prompt payment of the claim.** If you are submitting a CMS-1500 (12-90) Claim Form with an attachment, write "ATTACHMENT" in Box 10D and Modifier "22" in Box 24D.

- When billing Care Coordination and mileage together, **the Care Coordination must be listed first on the claim form**. If the mileage appears before the Care Coordination, there will not be a paid Care Coordination claim to match with the mileage claim, and the claim will deny. See the procedure codes below for Care Coordination and mileage:

Service	Procedure Code
Care Coordination Assessment and Service Plan	G9001
Monthly Care Coordination – Maternal	G9002
Monthly Care Coordination – Infant	G9002
Home Visit Travel	A0160

- Make sure claim submissions are fully completed and legible. **If the claim reviewer is unable to read the attachment or pertinent information is missing, the claim will pend and the provider will be notified to resubmit a legible and/or complete copy. If a legible and/or complete copy is not provided, the claim will deny.**

  DMAS regulations require the prompt submission of all claims within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the

last date of service. Federal financial participation is not available for claims, which are not submitted within 12 months from the date of service. Please refer to the "Timely Filing" section in Chapter V of the *Physician* Provider Manual for more details (all Provider Manuals are available online at www.dmas.virginia.gov).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Please remember that you cannot send electronic mail containing patient-identifiable and/or confidential information. DMAS will not respond to these emails if they are received.

You may contact someone about specific participant questions at the phone numbers listed below:

Nell Skinner:	1-804-371-8682
Ashley Barton:	1-804-371-7824
Fax:	1-804-786-5799

BABYCARE FORMS

Please review the attached revised BabyCare forms and begin using them. Starting on November 1, 2005, any Admission Packet or Outcome Report submitted using the old forms will be mailed back to the provider with a DMAS cover letter requesting that the Admission Packet or Outcome Report be resubmitted with the newest forms. DMAS will no longer accept Admission Packets or Outcome Reports missing the Maternal and Infant Care Coordination (MICC) Record (DMAS-50). As of November 1, 2005, all of the MICC forms will be available at the DMAS website (www.dmas.virginia.gov). Providers may access these forms by following the directions below:

- Go to www.dmas.virginia.gov online.
- Select "Search Forms" from the left-hand column.
- Under the "User" field, select "Provider."
- Under the "Category" field, select "MICC."
- Select "Search."

FAMIS MOMS

Effective as of August 1, 2005, a new program called FAMIS MOMS [see the July 8, 2005 Medicaid Memo, "Coverage Changes to the FAMIS Program (FAMIS MOMS & FAMIS Select) – Effective August 1, 2005," for more information] provides enrollees the same coverage that pregnant women currently receive from the Virginia Medicaid Program, including BabyCare Services. FAMIS MOMS will use the same systems (fee-for-service and managed care organizations) as Virginia Medicaid. Providers will use the same billing codes and billing procedures as they currently use for services provided to pregnant women covered by Medicaid. All providers who are approved to bill for Medicaid services to pregnant women are also approved to bill for services for FAMIS MOMS enrollees. FAMIS MOMS enrollees will also

pay the same co-payments as are charged to Medicaid-enrolled pregnant women. The one major difference between Medicaid and FAMIS MOMS is that once the baby is born, the child will not automatically be enrolled in FAMIS. The mother must apply for the baby's coverage in the birth month (see the August 19, 2005 Medicaid Memo, "FAMIS MOMS Enrollees – How to Apply for Newborn Coverage," for more information). An infant born to a mother who is eligible for FAMIS MOMS may be eligible for BabyCare Services if the infant is screened as high risk and is enrolled in Medicaid fee-for-service or FAMIS fee-for-service.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid provider identification number available when you call.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include upcoming changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-provider_newletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

Attached Number of Pages: (8)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MATERNITY RISK SCREEN

The risk screen is designed to identify high risk pregnant women as defined by the BabyCare program. Identify risks as listed below that apply to the client and make the appropriate referral(s). Please do not alter or add risks to the form. Additional information should be documented in the progress notes in the client's medical record.

Client Name _____ Medicaid # _____ EDC _____

Client's Address _____ Phone # _____

A. MEDICAL RISKS

1. _____ Hypertension, chronic or pregnancy-induced
2. _____ Gestational diabetes/diabetes
3. _____ Multiple gestation (twins, triplets)
4. _____ Previous pre-term birth < 5½ lbs.
5. _____ Advanced maternal age, > 35 yr
6. _____ Medical condition, the severity of which affects pregnancy, document below
   _____
7. _____ Previous fetal death

SUBSTANCE ABUSE	# days/ week used	# times/ day used
8. Alcohol		
9. Cocaine/crack		
10. Narcotics/heroin		
11. Marijuana/hashish		
12. Sedatives/tranquilizers		
13. Amphetamines/diet pills		
14. Inhalants/glue		
15. Tobacco/cigarettes		
16. Other drug, please specify		

_____

B. SOCIAL RISKS

1. _____ Teenager 18 years or younger
2. _____ Non-compliant with medical directions or appointments
3. _____ Mental retardation or history of emotional/mental problems
4. _____ Abuse, neglect during pregnancy
5. _____ Shelter, homeless or migrant

C. NUTRITIONAL RISKS

1. _____ Pre-pregnancy underweight/overweight Inadequate or excessive weight gain
2. _____ Obstetrical or medical condition requiring diet modification (document condition below)
3. _____ Poor diet or pica
4. _____ Teenager 18 years or younger

REFERRALS

1. ____ Care Coordination 2. ____ Nutritional Counseling 3. ____ Homemaker 4. ____ Parenting/Childbirth Class

5. ____ Glucose Monitor with nutrition counseling 6. ____ Smoking Cessation 7. ____ Substance Abuse Treatment

8. _____ No Care Coordination _____

PROVIDER COMMENTS/SUGGESTIONS _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER # _____

Referral to High Risk Care Coordination

DMAS-16 rev. 3/03

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

INFANT RISK SCREEN

Research supports the fact that indigent mothers and their high risk infants often need a combination of medical and non-medical services to assure positive infant health. The risk screen is designed to identify high risk infants as defined by the BabyCare program. Identify risks as listed below that apply to the client and make the appropriate referral(s). Please do not alter or add risks to the form. Additional information should be documented in the progress notes in the client's medical record.

Client Name _____ Medicaid # _____

Parent/Guardian Name _____

Client's Address _____ Phone # _____

A. MEDICAL RISKS

1. _____ Diagnosed developmentally delayed/ neurologically impaired
2. _____ Diagnosed medically significant genetic condition (including sickle cell disease)
3. _____ Birth weight - 1750 grams (3 lbs., 14 oz.) or less
4. _____ Chronic illness
5. _____ Diagnosed with fetal alcohol syndrome (FAS)
6. _____ Medical high-risk infant and pediatric care needed, but not available 24 hours a day
7. _____ Medical condition(s) the severity of which requires Care Coordination (document medical condition below)
8. _____ Born exposed to an illegal drug
9. _____ Failure to thrive or flattening of growth curve

B. SOCIAL RISKS

1. _____ Parent/guardian unable to communicate due to language barriers (e.g. non-English speaking, illiterate)
2. _____ Maternal absence (illness, incarceration, abandonment)
3. _____ Parental substance abuse/addiction (only include father if living in home)
4. _____ Caregiver's handicap presents risk to infant (physically impaired, hearing impaired, vision impaired)
5. _____ Caregiver mental illness/mental retardation
6. _____ Shelter, homeless, or migrant worker
7. _____ Mother 18 years or younger
8. _____ History of suspected abuse/or neglect
9. _____ Non-compliant with follow-up visits/screening visits and medical direction for this infant

C. NUTRITIONAL RISKS

1. _____ Congenital abnormalities affecting ability to feed or requiring special feeding techniques; poor sucking, severe or continuing diarrhea or vomiting; other conditions requiring diet modification
2. _____ Inadequate diet

REFERRAL:

1. _____ Care Coordination
2. _____ No Care Coordination

What services will the recipient receive? _____

PROVIDER COMMENTS/SUGGESTIONS: _____

_____

PROVIDER SIGNATURE & TITLE _____ SCREENING DATE _____

NAME AND TITLE PRINTED _____ PROVIDER ID # _____

REFERRAL TO HIGH-RISK CARE COORDINATION

DMAS-17 rev. 3/03

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL and INFANT CARE COORDINATION RECORD

INSTRUCTIONS: Complete this form on the initial home visit for all BabyCare recipients. *Items in italics apply to pregnant women only*. **Items in bold type apply only to infants.** Items in normal type apply to both women and infants.. **See explanation of codes on reverse of form.

1. Last Name _____ 2. First Name _____ 3. MI _____
For Infant, name of mother/guardian _____
4. Street Address _____ 5. City _____ 6. State_____ 7. Zip _____
8. Recipient's Medicaid ID # __ __ __ __ __ __ __ __ __ __ __ __ 9. Birthdate __ __ - __ __ - __ __ __ __

**10. Occupation (circle one) 0 1 2 9 **11. Marital Status (circle one) 0 1 9 **12. Education Level (circle one) 0 1 2 9
13. # of Live Births __ __ *14. Abortions __ __* *15. Miscarriages __ __* *16. Stillbirths __ __*
17. EDC __ __ - __ __ - __ __ __ __ *18. Weeks of gestation when prenatal care began __ __*

19. Provider Name _____ 20. Provider # __ __ __ __ __ __ __ __ __ __ __ __ 21.Visit Date __ __ - __ __ - __ __ __ __

Psychosocial Assessment	YES	NO		YES	NO		YES	NO
22. Conflict/violence in home	___	____	28. Insufficient funds for food	___	____	**34. Caregiver handicap**	___	___
23. Poor support system	___	____	29. Transportation need	___	____	**35. Maternal absence**	___	___
24. Poorly motivated	___	____	30. Neglect/Abuse	___	____	**36. Protective services**	___	___
25. Religious/ethnic factors affecting pregnancy	___	____	31. Childcare needs/poor parenting knowledge/pregnancy info	___	____	**37. Poor emotional bonding**	___	___
26. Housing needs	___	____	32. Multiple medical providers	___	____			
27. Family has urgent health needs	___	____	33. Mental retardation/ emotional problems	___	____			

General Medical Assessment	YES	NO		YES	NO		YES	NO
38. Multiple gestation	___	___	42. Genetic Disorder	___	___	**45. Infant chronic illness**	___	___
39. Prior preterm <5 1/2 lb.	___	___	43. Previous fetal/infant death or infant morbidity	___	___	**46. Developmental delay**	___	___
40. Advanced maternal age >35	___	___				**47. Infant apnea**	___	___
41. Medical condition affecting pregnancy/infant	___	___	44. Previous poor pregnancy experience - medical	___	___	**48. Birth weight < 3 lbs 14 oz**	___	___

Nutritional Assessment	YES	NO		YES	NO		YES	NO
49. Prepregnancy overwgt.	___	___	54. Poor basic diet info	___	___	59. Anemia	___	___
50. Prepregnancy underwgt.	___	___	55. Special diet/formula prescribed	___	___	**60. Inadequate sucking**	___	___
51. Excessive Nausea/Vomiting	___	___	56. Medical ondition affects diet	___	___	**61. Breast feeding problems**	___	___
52. Excessive wgt. gain	___	___	57. Inadequate cooking facility	___	___	**62. Poor use of**		
53. Inadequate wgt. gain	___	___	58. Mother age 18 or younger	___	___	**special formula**	___	___

Substance Abuse Usage At Current Time

	days/week	*times/day*		*days/week*	*times/day*		*days/week*	*times/day*
63. Alcohol	____	____	*66. Marijuana/hashish*	____	____	*69. Inhalants*	____	____
64. Cocaine/crack	____	____	*67. Sedatives/tranquilizers*	____	____	*70. Tobacco/cig.*	____	____
65. Narcotics/heroin/codeine	____	____	*68. Amphetamines/diet pill*	____	____	*71. Other*	____	____

Substance Abuse Usage Prior To Start Of Pregnancy

	days/week	*times/day*		*days/week*	*times/day*		*days/week*	*times/day*
72. Alcohol	____	____	*75. Marijuana/hashish*	____	____	*78. Inhalants*	____	____
73. Cocaine/crack	____	____	*76. Sedatives/tranquilizer*	____	____	*79. Tobacco/cig.*	____	____
74. Narcotics/heroin codeine	____	____	*77. Amphetamines/diet pill*	____	____	*80. Other*	____	____

81. Significant Findings

82. COORDINATOR'S SIGNATURE _____ 83. DATE __ __ - __ __ - __ __ __ __

DMAS-50 rev. 3/03

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL and INFANT CARE COORDINATION RECORD

Instructions for Completing DMAS-50 Form

1. Enter Recipient's Last Name. **Required.**
2. Enter Recipient's First Name. **Required.**
3. Enter Recipient's Middle Initial. **Required.**
4. - 7. Enter Recipient's Address. **Required.**
8. Enter Recipient's Medicaid ID Number. (NOTE: Enter the infant's number, not mother's, if recipient is an infant.) **Required.**
9. Enter the Birthdate of the Recipient in MM-DD-CCYY format. **Required.**
10. Circle the appropriate code for the Recipient's Occupation: **Required.**
    - 0 None (Attends school)
    - 1 Not heavy work (Any work outside the home, or in the home for pay, full time or part time, not included under heavy work.)
    - 2 Heavy work (Any work involving strenuous physical effort)
    - 9 Unknown
11. Circle the appropriate code for the Recipient's Marital Status: **Required.**
    - 0 Married
    - 1 Unmarried (single, separated or divorced)
    - 9 Unknown
12. Circle the highest Education Level reached by the Recipient: **Required.**
    - 0 High School graduate or higher
    - 1 9th to 12th grade
    - 2 8th grade or less
    - 9 Unknown

13. Enter the number of Live Births the mother has had.

14. Enter the number of Abortions the mother has had.

15. Enter the number of Miscarriages the mother has had.

16. Enter the number of Stillbirths the mother has had.

17. Enter the Estimated Date of Confinement (EDC) in MM-DD-CCYY format. **Required.**

18. Enter the number of Weeks gestation at which prenatal care began. **Required.**

19. Enter the Provider Name. **Required.**
20. Enter the Provider's Medicaid ID Number. **Required.**
21. Enter the date of the home visit in MM-DD-CCYY format. **Required.**

22. - 62. Assessments
Check "YES" if the indicated problem is a risk for the recipient. Check "NO" if it is not. (NOTE: Items in *italics* apply to pregnant women only. Items in normal type apply to both women and infants. Items in **bold** type apply only to infants.)

63. - 80. Substance Abuse Usage
Enter the **number** of days per week and the **number** of times per day the recipient uses or used each substance. If the recipient does not use the substance, leave the lines blank. If an entry is made in field 71 (Other), the name of the substance/drug must be listed.

81. Enter any Significant Findings discovered during the assessment.
82. Coordinator's Signature. The BabyCare Coordinator must sign the form. **Required.**
83. Date. The BabyCare Coordinator must date the form. **Required.**

For more complete information on BabyCare policy and procedures, please refer to the BabyCare Provider Manual.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL AND INFANT CARE COORDINATION

SERVICE PLAN

Client's Name _____ Client's Medicaid # _____

Date Primary Care Provider Notified of Client's Enrollment in BabyCare: _____

RISK NO.	DATE	IDENTIFIED NEEDS/PROBLEMS	PLAN	FOLLOW UP

I agree with this service plan and will work with my Care Coordinator to get the services I need.

Client's Signature: _____ Date: _____

Care Coordinator's Signature: _____ Date: _____

DMAS-52 rev 3/03

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PREGNANCY OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (month/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3. American Indian 4. Asian 5. Hispanic 6. Other [ ]			10. Provider Name & Address
8. Medicaid I.D. # Previous # if applicable			

11. Enter number of reason recipient is no longer requiring service: _____ **Date Closed**: _____

1. Pregnancy ended
2. Dropped out of prenatal care
3. Transfer to other MICC agency
4. Lost to follow-up
5. Eligibility cancelled
6. Problem resolved
7. Died
8. Moved
9. Other (Specify):

[ ]

12.. Pregnancy Outcome:

Instructions: Enter pregnancy outcome number only if the answer to item 11 is "1 - PREGNANCY ENDED"

1. Live birth
2. Spontaneous abortion
3. Therapeutic abortion
4. Elective abortion
5. Fetal death
6. Other:

[ ]

13. Infant's Live Birth Data

Instruction: Complete item 13 only if answer to item 12 is "1 - LIVE BIRTH"

	INFANT #1	**INFANT # 2**
Birth Weight lbs. and ozs.		
Birth Date		
APGAR Score 1 min.		
5 min.		

14. Weeks of gestation at time of birth _____

15. Infant Risk Screen

	Yes	No
a. Has Physician completed risk screen?		
b. If yes, was the infant classified as " high risk"?		
c. If yes, has the infant been referred to Care Coordination		
d. If yes, was the infant born with morbidity?		

16. Infant receiving EPSDT services _____ _____

17. Is the infant receiving WIC services**?**

Yes _____ No _____

18. Enter # of weeks of gestation when mother began prenatal Care: _____

19. Total # of prenatal visits by mother during this pregnancy: _____

20. Did mother receive WIC during Pregnancy?

Yes _____ No _____

21. Did mother receive postpartum or family planning exam?

Yes _____ No _____

22. Client Needs

Instructions: Indicate needs that were met through Care Coordinator assistance by entering "1" in appropriate space(s). Indicate client needs that were not met at the completion of Care Coordination by entering "2" in appropriate space(s).

1. Child Care _____
2. Food Stamps _____
3. Housing _____
4. Nutrition Serv. _____
5. Homemaker Serv. _____
6. Home Health Serv. _____
7. Employment _____
8. School Enrollment _____
9. Psychological _____
10. Job Training _____
11. Transportation _____
12. Substance Abuse Treatment _____
13. Smoking Cessation _____
14. Glucose Monitoring _____
15. Parenting/Childbirth _____

23. Substance abuse at time of delivery

Instructions: Item 23 must be completed if substance abuse was indicated on the Care Coordination Record (DMAS-50)

	# Days/ Week	# Times/ Day		# Days/ Week	# Times/ Day
Alcohol			Amphetamines/Diet Pills		
Cocaine/Crack			Inhalants/Glue		
Narcotics/Heroin			Tobacco/Cigarettes		
Marijuana/Hashish			Other (Specify)		
Sedatives/Tranquilizers			_____		

Coordinator's Signature _____ Date _____

DMAS-53 rev. 3/03

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (mo/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3 American Indian 4. Asian 5. Hispanic 6. Other [ ]			10. Provider Name & Address
8. Medicaid I.D. # Previous # (if applicable)			

11. Enter the infant's birth weight and Apgar scores:

A. Birth weight: lbs. _____ oz. _____ B. Apgar: 1 min. _____ 5 min. _____

12. Enter reason infant is no longer receiving Care Coordination Services: [ ] Date closed: _____

1 - Reached age two
2 - Dropped out of well-child care
3 - Transfer to other MICC agency
4 - Lost to follow-up
5 - Eligibility cancelled
6 - Problem resolved
7 - Died
8 - Moved
9 - Other

Instructions: Complete items 13 & 14 only if answer to item 12 is "Died"

13. Enter the infant's age at death (months and weeks) months _____ weeks _____

14. Enter primary cause of infant's death: [ ]

1 - Accident 2 - Congenital abnormality 3 - Birth trauma 4 - Non-congenital illness

Instructions: Complete items 15 through 17 if answer to item 12 is "Died" or "Reached Age Two"

15. Enter total number of prenatal visits by mother during this pregnancy: [ ]

16. Enter number of weeks of gestation when mother began care: [ ]

17. Indicate if mother received Care Coordination Services during this pregnancy: [ ]

1 - Yes 2 - No

Instructions: Complete items 18 through 22 only if answer to item 12 is "Reached Age Two"

18. Enter child's health status at age two: [ ]

1 – Normal health & development
2 – Developmentally delayed
3 – Congenital abnormality
4 – Non-congenital disease

19. Enter child's living situation at age two: [ ]

1 – With parent/guardian 2 – Foster care placement 3 – Long term care facility

20. Enter total number of EPSDT visits during first two years: [ ]

21. Indicate if child is receiving WIC benefits 1 - Yes 2 - No [ ]

22. Enter child's height and weight at age two:

Height: ft. _____ in. _____ Weight: lbs. _____ oz. _____

23. Client Needs

Instructions: Indicate needs that were met through Care Coordinator assistance by entering **"Y" (Yes)** in the appropriate block(s). Indicate clients needs that were not met at the completion of Care Coordination Services by entering **"N" (No)** in the appropriate block(s):

[ ] 1. Child Care [ ] 2. Food Stamps [ ] 3. Housing [ ] 4. Nutrition Counseling [ ] 5. Parenting Education [ ] 6. Home Health Services [ ] 7. Employment [ ] 8. Counseling [ ] 9. School Enrollment [ ] 10. Job Training [ ] 11. Transportation

_____ _____
Coordinator's Signature Date

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE
MATERNAL AND INFANT CARE COORDINATION

Letter of Agreement

The Department of Medical Assistance Services wants you to be healthy and have a healthy baby. Your Maternal and Infant Care Coordinator (MICC) can help you find and get the services you or your infant may need.

Your MICC can help you get:

Medical Care
WIC Services
Home Health Services
Transportation
Information About Other Services

And if you are pregnant:

Nutrition Services from Registered Dietitians
Homemaker Services
Information About Pregnancy and Child Care

Your MICC is there to help you!

Your responsibilities in Care Coordination are to:

- Get prenatal or well-child care and WIC as soon as possible.
- Keep all appointments.
- Tell your MICC about your needs during pregnancy, or as a new mother.
- Let your MICC know how to reach you.
- Do your best to follow your plan for having a healthy baby.

Both the MICC and the client must sign this Letter of Agreement to begin Care Coordination Services. Care Coordination Services may be delivered by one or more coordinators in the agency.

I understand my part and wish to get Care Coordination Services. Prenatal care and other Medicaid benefits will not stop if I choose not to get Care Coordination Services. I agree my Care Coordinator may share medical information about me or my infant with my health care providers under the rules covering patient privacy as specified by HIPAA.

I understand my part of Care Coordination Services and will work with the client to help her receive the services she needs.

_____
Medicaid Eligibility #

_____
Print Name of Client

_____
Signature of Client/Guardian

_____
Date

_____
Coordinator Signature

_____
Coordinator Provider #

_____
Date